UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

REMICADE (infliximab)

Patient name:_____Medicaid or SS#_____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and options:_____Fax#_____

Physician's NPI_____

Diagnosis_____Current wt_____mg/kg_____

Administered every_____weeks starting (date)_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

Covered for the following diagnosis of:

1. **Ulcerative Colitis**:

   Moderate to severe Ulcerative Colitis

   Has failed conventional therapy (i.e.5-aminosalicylates, antibiotics, MTX, 6- mercaptopurine, azathioprine, corticosteroids, budesonide)

2. **Crohn's Disease**:

   Moderate to severely active Crohn's

   Failed conventional therapy (i.e.5-aminosalicylates, antibiotics, MTX, 6-mercaptopurine, azathioprine, corticosteroids, budesonide)

3. **Rheumatoid Arthritis and Ankylosing Spondylitis**

   Moderate to severely active Rheumatoid Arthritis and Ankylosing Spondylitis

   Given in combination with methotrexate

4. **Psoriatic Arthritis**

   Active Psoriatic Arthritis.

5. **Plaque Psoriasis**

   Chronic severe (i.e. extensive and/or disabling) plaque psoriasis who are candidates for systemic therapy, and when other systemic therapies are medically less appropriate.

INFORMATION:

To be given in clinic setting only. Patients with HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code 1745 and PA number.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

An updated letter or progress notes need to be sent in showing improvement or maintenance with medication.